
Guest editorial

Paid organ donation - the Grey Basket concept

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Few questions in biomedical ethics are as challenging at present as the question of paid organ donation for transplantation, raising as it does difficult issues related to the body, the soul, property rights, autonomy, limitations to freedom, cultural/ethical pluralism and professional versus societal perceptions. The arguments against paid donation are familiar. Here I look at the less familiar countervailing arguments.

The shortage of organs is getting worse and significant numbers of patients are dying on waiting lists. There is fear that as the situation worsens, unethical behaviour will likely become criminal behaviour. Xenotransplantation and tissue engineering offer some hope for the future, but at present it appears that there are no methods of increasing donation that are not themselves seriously controversial.

For these and other reasons, the question of payments for organs is currently very topical. The 1998 Aristotle Onassis Award for Best Theatrical Play went to an Indian playwright, Manjula Padmanaban, for her play, *Harvest*, a grim portrayal of the organ trade in an Indian village in the year 2010 AD. The Ashkenazi Chief Rabbi of Israel, basing his opinion on the rabbinical scholars Shlomo Zalman Auerbach and Shaul Yisraeli, declared earlier this year that Jewish law permits the sale of organs if their removal does not harm the donor's health.¹ (Unilateral nephrectomy in healthy donors is accepted by the profession as safe enough now to constitute over 30% of kidney transplants in the USA, nearly 50% in Norway and nearly 100% in much of the rest of the world.) Father Healy, a Catholic priest and bioethicist, presenting a paper a few months ago at the Congress of the Asian Society of Transplantation in Manila, declared that in the context of Filipino society, an indiscriminate ban on payment for organs is inappropriate. He went on to quote Pope Pius XII who said, in reference to cadaveric corneal donation, that "it would be going too far to declare immoral every acceptance or demand

for payment ... it is not necessarily a fault to accept it".² The 1997 Bellagio Task Force Report on Transplantation, Bodily Integrity and the International Traffic in Organs,³ found no unarguable ethical principle that would justify a ban on the sale of organs under all circumstances; this is a position held by many other secular scholars, for example Englehardt,⁴ Sells,⁵ Dossetor,⁶ and Radcliffe-Richards *et al.*⁷ (See reference 8 for a review). The publication recently in the *Lancet* of a controversial paper by the International Forum on Transplant Ethics,⁷ was greeted by enormous international media attention, with a number of editorials agreeing with the position taken by the authors that the debate on organ sales needs to be reopened, since pragmatically, at least, more harm than good seems to result from the worldwide ban.

Radcliffe-Richards *et al* have demonstrated that almost all the familiar arguments against the sale of organs, for example, exploitation, lack of informed consent, level of risk assumed by the vendors/donors, difficulty of control/regulation of the sale of organs, lack of fairness for the rich to have privileges that the poor do not have, absence and erosion of altruism as the basis for donation of organs, undermining of confidence in the medical profession, etc, are all deficient and cannot stand up to robust scrutiny.

Furthermore, since it appears at the outset that allowing the regulated sale of organs would increase their supply to those who desperately needed them, the onus of proof must be with those who oppose this position to demonstrate why a worldwide ban should be maintained. The Kantian argument that selling a body part is degrading does not always apply, as degradation very much depends on one's own perception of what is degrading. And the very familiar slippery slope arguments, were they to form the basis of public policy, would exclude almost every public

activity that had the slightest risk (driving, scuba diving, nuclear reactors). *We cope because we regulate.*

Medical professionals accept autonomy as a major bioethical principle, but are repulsed by the autonomous wish of the donor of a kidney to obtain money, resulting in what we have called the "autonomy paradox",⁹ even when the money is needed for purely altruistic reasons, for example to buy medication to save the life of a beloved daughter. John Dossetor⁶ has argued very effectively that the burden-benefit equation in these "indirect altruism" circumstances would justify allowing such payments, at least in those cultures where this would be acceptable and under circumstances where the alternatives for potential recipients would be death because dialysis was not available. A woman in the US recently offered to sell a kidney to pay for a laparoscopic cholecystectomy; she found this to be against the law. The bigger question here is the morality of legislation that bars a life-saving option for an individual while failing to provide societal relief. If it is moral to allow 20% of your population to have no medical insurance because your society is based on free markets and rugged individualism, and damn those who are incapable, surely such a society would value a presumption for autonomy in decisions on how best to find remedy?

Whiff of hypocrisy

There is also a whiff of hypocrisy about the profession's attitude to the subject. In a recent article¹⁰ I proposed a ten-point charter meant to increase living renal donation generally. Half in jest I included a point which suggested that transplant teams should be the first to encourage altruism by forgoing part of their usual fees. I was only partly surprised at the number of letters I received objecting to that particular point while agreeing with the other nine. Dickens¹¹ has wondered why when hospitals, laboratories, pharmaceutical companies, physicians, surgeons etc, financially benefit from transplantation, it is only from the donor that we demand unmitigated altruism, which manifestly fails to distinguish donor from vendor anyway.⁷ Childress, in relation to this very question, has pointed out that altruism is over-estimated as the basis of human behaviour.¹² We should try to base organ donation on altruism, but how often do we hold that if an action is not based on altruism we should ban it altogether?

The subject is obviously much more complex than would appear at the outset. How, then, does one approach it? We have introduced a classification¹³⁻¹⁴ based on the (much misunderstood) concept of gifting. The aim was to clarify

the issues, accept and reject the obvious early in the discourse, and focus on the contentious. For living kidney donors, the categories were 1) living (genetically) related donors; 2) living (emotionally) related donors; 3) donation by altruistic strangers (is there a good reason why not?); 4) the Grey Basket; 5) rampant commercialism (no checks, balances, and including exploitation by middlemen) 6) criminally coerced procurement. It seems to me that categories 1-3 are easily acceptable, while 5 and 6 are not. This allows us, then, to concentrate on the Grey Basket concept, which would admit any principle-based idea to critical scrutiny. It might contain ideas such as the Donors' Trust,⁵ whereby there are societal/professional mechanisms to separate payments from treatment, and available funds to ensure equal access. Francis Moore hinted at something like this when he said that "selling of kidneys from living donors, evidently a common practice in India, finds a negative response in our society unless the recipients are chosen without respect to ability to pay, ie some form of government subsidy"¹⁵; or, there are Dossetor's ideas, which take into account cultural and economic realities and which refer to "indirect altruism" and "mandated philanthropy".⁶

What is perhaps surprising is that paid organ donation is not more common than it actually is. Ask any economist and you will learn that the combination of demand, scarcity and need automatically equals a black market. As I write there is a debate taking place on the worldwide web magazine, *Slate*, between a physician and Richard A Epstein, a well-known economist who convincingly argues, as have other Chicago (where else) economists, for the introduction of market mechanisms.¹⁶ Readers are asked to vote online as the debate unfolds and currently, in answer to the question "Is organ peddling ethical?" the majority response is in favour - which is in keeping with other polls in the past.¹⁷ The Stanford/Hoover Institution Nobel Prize winner Gary S Becker also believes that introducing market mechanisms will substantially ease the shortage of organs, and that one possible market structure would be to grant authority to buy and sell (cadaveric) organs exclusively to the federal government.¹⁸

Confusion and complexity

Four months ago a highly respected Israeli transplant surgeon was alleged to have been involved in six kidney transplants on Israelis in Estonia using organs that had been sold by Romanians.¹⁹ He denied knowing that the kidneys were sold, but said he encourages expanding the supply of organs for people who would die without them. Appar-

ently, three members of the Knesset are now in the process of introducing legislation to legalise the sale of organs, but this is opposed by the Ministry of Health. In miniature, this split symbolises the confusion and complexity of this subject.

We were amongst the first to show the negative effects of unregulated commercially obtained organs in India in the late 1980s.²⁰ India now has a law banning such commerce, defining death through brain stem death criteria and theoretically facilitating cadaveric donation. The government, however, beset by other more pressing health care needs, hardly caters to end stage renal disease, and does not provide dialysis. As a result, most observers believe that the law has not stopped paid organ donation in India.

There are honest teams working hard to define the acceptable at the same time that unscrupulous teams are exploiting the shortage of organs to enrich themselves, using patients as the tools. In this complex debate, knee-jerk reactions have in the past failed to stop paid donation, because the arguments were flawed and did not take into account realities on the ground. They were based mainly on emotions such as revulsion and disgust, whereas the very reason we have ethical discourse is so that emotions, rather than value-based reasoning, do not become the basis of accepted behaviour.

So where do we go from here? Some of the following lend themselves to serious consideration:

- Reduction of disincentives for living donors, paying them those types of compensation such as for time off work, child care, medical expenses, etc. It is amazing that at least since 1985 when the (International) Transplantation Society explicitly said that such payments are ethically acceptable,²¹ nothing serious has been done about their introduction and regulation. The subject should now take priority. Ethically acceptable models, for example in Sweden, already exist.
- Consideration of incentives, monetary or otherwise, to increase donation. The American Medical Association has actually accepted "futures markets" for cadaveric organs²² as an expression of individual autonomy; the transplant profession has not accepted this decision. Pennsylvania Act 102 allows payment of up to US\$3,000 to families who consent to donation of organs of their recently deceased relatives; apparently donation rates have improved, but there are as yet no published studies of the contribution of the other components of that law.
- Review of laws based on suspicion. Is ULTRA (Unrelated Living Transplant Regulatory Authority, part of British transplant law) still

relevant? What ethical truth is there in basing donation on genes rather than on relations? Who would you rather donate to: a wife (or a dear friend) with whom you have enduring bonds and shared values and companionship, or a sibling you last met 20 years ago? Such category 2 transplants are now commonly performed in the US.

- Keeping an open mind for the contents of the Grey Basket. We should stop being dainty where money is concerned. The public, whose opinion often subconsciously arbitrates when we do not know what path to follow, has often been more open to some types of payments than has the medical profession. Our old cosy professional ethics have also been transformed into bioethics - decisions are no longer in our exclusive domain. Individual medical professionals are of course free to draw the line wherever they feel comfortable as a way of expressing their own autonomy.
- Continuation of this discourse until a major breakthrough, xenotransplantation or tissue engineering or some other unforeseen event, materialises. Adoption of the Spanish model,²³ which at peak provides about 27 donors per million population per year (pmppy), would be a significant move forward, but it might not translate easily, and will not significantly impact countries like the the US or Egypt, where the incidence of end stage renal disease is over 200 pmppy, and where, as in the latter case, there is no cadaveric donation anyway.
- If we do not come up with better and sustainable arguments for the ban there will be increasing pressure to consider a scientifically valid trial of paid donation under controlled conditions whereby the interests of all parties concerned are looked after, abuse is minimised, and access is guaranteed to both the rich and the poor. Ironically, such a trial will need to be performed in a country where the rule of law is respected, the likelihood of corruption minimal, and transparency is guaranteed²⁴. It is just possible that under these conditions the abuse we currently see will be eliminated.

Perhaps the ethical litmus test is not whether the giver is a vendor or donor, but whether the physician is a profiteer or healer.

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News and notes

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